August 20, 2018

Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue NW
Suite CC–5610 (Annex C)
Washington, DC 20580

Re: Comments to the Federal Trade Commission (FTC)'s Competition and Consumer Protection in the 21st Century Hearings, Project Number P181201; the state of antitrust and consumer protection law and enforcement, and their development, since the Pitofsky hearings (Docket No. FTC-2018-0048)

Dear Sir or Madam:

The National Community Pharmacists Association ("NCPA") appreciates the opportunity to provide comments to Competition and Consumer Protection in the 21st Century Hearings, Project Number P181201; the state of antitrust and consumer protection law and enforcement, and their development, since the Pitofsky hearings (Docket No. FTC-2018-0048). NCPA represents the interests of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together, they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis. NCPA will be commenting on the health care industry in anticipation of the FTC series of hearings.

Competition and consumer protection standards in the health care industry are ripe for review. Recent consolidation amongst major Pharmacy Benefit Managers (PBMs) in the health care industry has contributed to increasing health care costs and negatively impacted consumer choice. PBMs have extraordinary market power; the top three PBMs control approximately 89% of the market: 238 million lives[1] out of 266 million lives.[2] This dominance has allowed PBMs to leverage their market power to the detriment of plan sponsors (government and commercial payors), providers and consumers. Additionally, PBMs claim that they help plan sponsors generate savings by negotiating rebates, however, recent reports have shown the opposite. A recent report from May 2017 found that PBMs have been utilizing their market power to try to increase their profits and encourage higher list prices for prescription drugs, which increases co-pays for patients.

[1] Mathematical calculation based on number of covered lives CMS/Caremark, UnitedHealth and ESI self-reported.
[2] From testimony of PCMA CEO Mark Merritt before the U.S. House of Representatives Energy & Commerce Committee Subcommittee on Health, December 13, 2017.

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In order to address PBM market dominance, NCPA has long argued for increased transparency in PBMs' business practices, additional scrutiny of inherent PBM conflicts of interest, and fair contract negotiation between PBMs and independent pharmacies. Even though beneficiaries and plan sponsors rely on PBMs in plan benefit design, PBMs operate without transparency by failing to disclose key plan details that may financially enrich the PBM. In addition, PBMs own mail order and specialty pharmacies while simultaneously setting reimbursement rates for retailers that compete with PBM-owned pharmacies, thus creating a conflict of interest. Lastly, NCPA continues to express concern over PBMs' leverage over the contract process, which forces pharmacies to accept contracts that are anticompetitive, one-sided, onerous and detrimental to patients. We urge the FTC to take a closer look at the PBMs anticompetitive practices to ensure consumers have access to prescription drugs in the most transparent and cost-effective manner.

PBMs Mislead Consumers due to a Lack of Transparency

PBMs are manipulating the system to increase their own profits at the expense of consumers, employers, and government programs. PBMs have a unique vantage point in the middle of the supply chain to have access to critical claims and financial data by their contracts with manufacturers and pharmacies and due to their multitude of revenue streams. They negotiate rebates with pharmaceutical manufacturers and determine which drugs are included on PBM formularies, ultimately determining what drugs patients will have access to and at what cost. They also contract with employers to manage their prescription drug benefit, and in doing so, heavily influence prescription drug benefit designs.

PBMs typically enter into contracts in which they will assume no fiduciary duty to employers or plan sponsors. As a result, the PBM has no affirmative obligation to disclose that certain plan benefit designs may financially enrich the PBM or that the PBM may be profiting from the sale of claims data derived from that plan sponsor. Ultimately, this enables PBMs to operate without transparency that would enable plan sponsors and beneficiaries to determine PBM cost-effectiveness.

PBMs have expressly indicated that they have no responsibility to manage costs. Earlier this year, the city of Rockford, Illinois sued Express Scripts, expressing concerns over expensive prescription drugs financially crippling the whole city. In its motion to dismiss, Express Scripts denied any wrongdoing and argued that it is not "contractually obligated to contain costs."[3] A fiduciary duty would force PBMs to consider plans' financial interests, and therefore obligate PBMS to help contain costs in the drug supply chain.

Further, the PBM rarely reimburses the pharmacy the same amount it charges the plan for a particular drug. Typically, the PBM "marks up" the cost of the drug, charging the plan more than the pharmacy is reimbursed, and keeps the difference as profit. It is precisely these hidden spread amounts that need to be disclosed to plan sponsors and consumers. A fiduciary duty would force

[3] 60 Minutes*, The Problem with Prescription Drug Prices* (May 6, 2018), *available at* https://www.cbsnews.com/news/the-problem-with-prescription-drug-prices/.

PBMs to put plans' financial interests before their own. With increased transparency of these spread amounts, plan sponsors would have greater ability to negotiate more competitive contracts. Therefore, NCPA urges the FTC to support efforts of the health care industry to require PBMs to have a fiduciary duty to the entity for which they manage pharmaceutical benefits. This would effectively shed light on opaque PBMs' practices that are aggressively increasing senior and taxpayer costs.

PBMs Conflicts of Interest

PBMs' inherent conflicts of interest in the healthcare marketplace warrant further scrutiny. Each of the largest PBMs own mail order pharmacies and specialty pharmacies. PBMs also contract with all other retail pharmacies to form pharmacy networks that are direct competitors to the PBM-owned pharmacies. PBMs regularly design plans, including plans with preferred networks, that require or incentivize patients to use the PBM-owned pharmacy option over a retail pharmacy. Moreover, when a PBM contracts with a retail pharmacy, PBMs have wide latitude in setting requirements for a pharmacy to be included in a network: the PBM determines how much the pharmacy will be reimbursed, which drugs will be covered, the day supply that the pharmacy can dispense, the patient co-pay, and many other factors. PBMs also routinely audit retail pharmacies and through this process have access to purchasing records and invoices.

When PBMs own mail order or specialty pharmacies, PBMs utilize such road blocks to steer patients to the PBM-owned pharmacies. Specifically, in the specialty pharmacy space, due to the lack of an industry-wide definition of a specialty drug, PBMs arbitrarily define high-cost drugs as "specialty drugs" and encourage or require that beneficiaries fill these prescriptions at PBM-owned or affiliated specialty pharmacies. Forcing patients, particularly those who have complex conditions and require specialty drugs, to get their prescriptions from a pharmacy with which it has no personal relationship severely limits patients' choice and may impact the quality of care and adherence.

In addition, it is a common misconception that steering patients into mail order will lower drug costs for consumers.[4] Evidence demonstrates that mail order pharmacies consistently dispense costlier brand-name drugs and fewer generics than retail pharmacies. Because PBMs are hindering patient choice and access, while steering patients towards costlier drugs, we urge the FTC to closely examine PBM-owned mail order and specialty pharmacies for conflicts of interest misconduct.

PBMs Issue One-Sided, Non-Negotiable Contracts

PBM contracts with pharmacies are often one-sided and non-negotiable. Most often, community pharmacists are forced to sign these take-it-or-leave-it contracts from PBMs with unilateral provisions and offensive language. If the pharmacy "chooses" not to sign, the pharmacy will not

[4]A Comparison of the Costs of Dispensing Prescriptions through Retail and Mail Order Pharmacies, available at http://www.ncpanet.org/pdf/leg/feb13/comparison_costs_dispensing_prescriptions_retail_mail_order.pdf.

be able to fill prescriptions for that plan sponsor's patients, thus losing a significant percentage of its business. These contracts contain multiple provisions that include overly broad confidentiality requirements and non-disparagement clauses, which are sometimes embedded in lengthy provider manuals. PBMs update their provider manuals at their discretion and hold pharmacies responsible for staying abreast of these updates but claim essentially no obligation to notify the pharmacy of such updates. For example, a PBM included the following language in their contract:

> **Unilateral:** It shall be the Provider's responsibility to check for any updates to the Provider Manual to ensure that Provider has the most recent version of such Provider Manual; provided, however, **whenever reasonably possible**, XXX will notify PSAO within 30 days after the Provider Manual is updated. The Provider Manual may be revised from time to time by XXX in its sole discretion.

As shown above, PBMs place strict requirements on pharmacies to follow the contract terms but relieve themselves of any responsibility to ensure the provisions are fair. In addition, PBMs include vague confidentiality language that prohibit pharmacists from discussing drug costs, services, business practices or "other information" contained in the contract or Provider Manuals. Some PBMs have even included provisions that pharmacists interpret as prohibiting communication with news media, policy makers and elected officials. For example, some of the largest PBMs have included the following provisions in their contracts and Provider Manuals:

> **Confidentiality:** Any information or data obtained from, or provided by, XXX or any Benefit Sponsor to the Participating Pharmacy is confidential. This includes, but is not limited to, products, programs, services, business practices, procedures, MAC lists or other information acquired from the contents of the Pharmacy Participation Agreement, Provider Manual and related Exhibits or other XXX documents.
>
> **Contacting Sponsors or Media**: Provider hereby agrees (and shall cause its affiliates, employees, independent contractors, shareholders, members, officers, directors and agents to agree) that it shall not engage in any conduct or communications, including, but not limited to, contacting any media or any Sponsor and/or Sponsor's Members or other party without the prior consent of [PBM].

These overly-broad confidentiality provisions essentially prohibit pharmacist communications with patients and others for fear of retaliation by the PBM. Violation of any of these provisions or others may lead the PBM to terminate the contract with the pharmacy and remove the pharmacy from the PBM's networks. This results in the inability of the pharmacy to continue to service a substantial portion of its customers, potentially causing access problems for patients and subjecting the pharmacy to retaliation in the form of abusive audits. Therefore, NCPA asks the FTC to evaluate PBMs' negotiation and contracting strategies.

Conclusion

NCPA greatly appreciates the opportunity to share with you our comments and suggestions on Competition and Consumer Protection in the 21st Century Hearings, Project Number P181201; the state of antitrust and consumer protection law and enforcement, and their development, since the Pitofsky hearings (Docket No. FTC-2018-0048).

Sincerely,

Ronna Hauser, PharmD

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